ATTACHMENT 1

MAPB-087-014-D
Date: 9/1/87

Physical Therapy Services

FORM APPROVED
OMB NO. 0938-0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

[ ] MEDICARE (MEDICARE NO.) [T] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [ ] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Recipient Im A.

2 PATIENT'S DATE OF BIRTH: MM | DD | YY

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Same

4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow
Anytown WI 53725
TELEPHONE NO

5 PATIENT'S SEX: MALE [X] FEMALE [ ]

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS): 1234567890

7 PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]

8 INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER): OI - S

10 WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT: YES [ ] NO [X]
B. ACCIDENT: AUTO [ ] OTHER [ ]

11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE): M-5
TELEPHONE NO

11.a CHAMPUS SPONSOR'S
STATUS: ACTIVE DUTY [ ] DECEASED [ ] RETIRED [ ] BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW
SIGNED / DATE / / / / / / /

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
SIGNED (INSURED OR AUTHORIZED PERSON) / / / / / / / / / / / / / /

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES / / / / / / / / / / / /

16.a IF EMERGENCY CHECK HERE [ ]

17 DATE PATIENT ABLE TO RETURN TO WORK / / / / / / / /

18 DATES OF TOTAL DISABILITY FROM / / / / / / / / THROUGH / / / / / / / /

DATES OF PARTIAL DISABILITY FROM / / / / / / / / THROUGH / / / / / / / /

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY): I. M. Referring 12345678

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED | DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE): I. M. Nursing home 12345678

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
1 435.9
2 437.0
3
4

B
EPSDT YES [ ] NO [X]
FAMILY PLANNING YES [ ] NO [X]

PRIOR AUTHORIZATION NO. 1234567

24 A DATE OF SERVICE FROM	TO	B * PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G * T.O.S.	H LEAVE BLANK
02/03,05,07/88		7	97200	Whirlpool/therapeutic ex. 60 min. ea.	1	XX XX	6.0	1	
02/23/88		7	97100	Gait training 30 min.	2	XX XX	1.0	1	
02/01/88		7	97700	Evaluation 60 min.	1	XX XX	2.0	1	
				I. M. Performing					
				12345678					
									Patient Spenddown $

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
DATE: MM/DD/YY I.M. PROVIDER

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) / / YES [ ] / / [ ] NO / /

27 TOTAL CHARGE XX XX

28 AMOUNT PAID XX XX

29 BALANCE DUE XX.XX

30 YOUR SOCIAL SECURITY NO.

31 PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
I.M. Billing
1 W Williams
Anytown WI 53725
I.D. NO 87654321

32 YOUR PATIENT'S ACCOUNT NO.
1234JED

33 YOUR EMPLOYER I.D. NO.
/ / / / / / / / / / / /

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK
REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

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